ICLUSIG® Direct

Customer Information and Application

Please contact Foundation Care directly at 833.291.2773 to place orders for ICLUSIG®.

Legal Name: _____ d/b/a: _____

Main Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Federal Tax ID: _____ DUNs Number: _____

Primary Contact Name: _____ Phone Number: _____

Accounts Payable Contact Name: _____ Accounts Payable Phone Number: _____

Accounts Payable Fax: _____ Accounts Payable Email: _____

Bill to Address (if different than main address): _____

City: _____ State: _____ Zip Code: _____

Ship to Address* (if different than main address): _____

City: _____ State: _____ Zip Code: _____

***If multiple ship to locations, write, 'See Attached' in the shipping address field and complete the multiple sites form on page 3.**

Ownership Type: ☐ Proprietorship ☐ Partnership ☐ Limited Partnership ☐ LLC ☐ (S) Corp ☐ (C) Corp
☐ Other _____

Owners and/or Officers Names and Titles:

FoundCare.com
P: 833.291.2773
4010 Wedgeway Court, Earth City, MO 63045
FCPIclusig@Foundcare.com

Foundation Care™
An AcariaHealth Solution

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Customer Information and Application (Continued)

Have you ever filed for bankruptcy? ☐ Yes (Attach explanation) ☐ No

Are you eligible to purchase as a 340B entity? ☐ Yes ☐ No If YES please ensure to complete the 340B Attestation listed on the website

Additional Information:

Please attach the following documentation to this application:

- DEA Registration
- Annual Financial Statements for the last 3 years (please include balance sheets, income statements, etc.)
- W-9
- Copies of 3 most recent and consecutive primary supplier statements
- Copy of Resale/Tax Exemption Certificate

Credit References (one of which must be a primary bank reference and one of which must be a supplier):

1. Name: _____ Contact Person: _____

   Phone Number: _____ Email: _____

2. Name: _____ Contact Person: _____

   Phone Number: _____ Email: _____

3. Name: _____ Contact Person: _____

   Phone Number: _____ Email: _____

Do you wish to be contacted about Specialty Pharmacy services? ☐ Yes ☐ No

Note that invoice payment will be due 30 days from date of invoice.

Signature: _____ Title: _____

Print Name: _____ Date: _____

Please email completed form to **FCPiclusig@foundcare.com**.

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Customer Information and Application (Continued)

Please use this form if additional space was needed for previous parts of the application.

Additional Shipping Addresses:

1. Location Name: Street Address:

   City: State: Zipcode: ☐ 340B ☐ WAC

   State License No.: DEA No.: Phone No.:

   Contact Name: NPI No. (if applicable):

2. Location Name: Street Address:

   City: State: Zipcode: ☐ 340B ☐ WAC

   State License No.: DEA No.: Phone No.:

   Contact Name: NPI No. (if applicable):

3. Location Name: Street Address:

   City: State: Zipcode: ☐ 340B ☐ WAC

   State License No.: DEA No.: Phone No.:

   Contact Name: NPI No. (if applicable):

4. Location Name: Street Address:

   City: State: Zipcode: ☐ 340B ☐ WAC

   State License No.: DEA No.: Phone No.:

   Contact Name: NPI No. (if applicable):

Please email completed form to **FCPiclusig@foundcare.com**.

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